APPLICATION FOR SUPPLEMENT TO MEDICARE

Regence BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
1800 Ninth Avenue • P.O. Box 91053
Seattle, Washington 98111-9153
206 464-3804 • 1 888 344-5594

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM.

- You do not need more than one Medicare supplement contract.
- If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.
- The benefits and rates under your Medicare supplement contract can be suspended, if requested during your entitlement to benefits under Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your contract will be reinstituted if requested within 90 days of losing your Medicaid eligibility.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

PLEASE PRINT. Answer all questions completely and accurately to ensure timely processing.

Name	Birth Date	Social Security Number
Address		
Telephone	❒ Male ❒ Female	❒ Single ❒ Married

Please copy the information from your Medicare card onto the sample card at right, or attach a copy of your Medicare card, or the Letter of Verification from the Social Security Administration or Railroad Retirement Board.

This information is required to process your application.

MEDICARE HEALTH INSURANCE

HEALTH CARE FINANCING ADMINISTRATION

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER SEX

IS ENTITLED TO: EFFECTIVE DATE

HOSPITAL (PART A)

MEDICAL (PART B)

Coverage Applied For

A - Base Plan
- ❒ By reason of Age (65 or older)
- ❒ By reason of Disability (under age 65)

❒ **C - Cascade Plan**

❒ **E - Alpine**

❒ **F - Vista Plan**

❒ **I - Summit Plan**

Type of Billing Desired

❒ Automatic Bank Withdrawal *(Complete the Subscriber Agreement for Preauthorized Bill Payment form)*

❒ Standard Billing/Payment by Check *(Indicate desired billing schedule below.)*

❒ Monthly ❒ Bimonthly ❒ Quarterly ❒ Semiannually ❒ Annually

FOR OFFICE USE ONLY

Broker # Package # Effective Date

TYPE OF APPLICATION

❒ New

❒ Transferring from another Blue Shield plan.

- Name of Plan _____

❒ Converting from a Regence BlueShield group.

❒ Converting from another company.

- Name of company _____
- Name/type of policy _____

TO THE BEST OF YOUR KNOWLEDGE....

Yes **No**

❒ ❒ Do you have another Medicare supplement policy or certificate in force?

If Yes: a. With which company? _____

b. Do you intend to replace your current Medicare supplement policy with this contract? ❒ Yes ❒ No

❒ ❒ Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement contract?

If Yes: a. With which company? _____

b. What kind of policy? _____

❒ ❒ Are you covered for medical assistance through the state Medicaid program?

If Yes: ❒ As a "Specified Low-Income Medicare Beneficiary" (SLMB).

❒ As a "Qualified Medicare Beneficiary" (QMB).

❒ For other Medicaid medical benefits.

HEALTH STATEMENT REQUIREMENTS

Completion of the following Health Statement is not required for every applicant. Please read the following information carefully to determine if you are required to complete it.

It is **not** necessary to complete the health statement if you are:

- ✦ Applying within six months of your first enrollment under Medicare Part B; *or*
- ✦ Applying within six months of turning age 65; *or*
- ✦

Transferring from:		*Transferring to:*
Plan A	➠	Regence Base Plan (A)*
Plan I	➠	Regence Summit Plan (I)
Plans B, C, D, E, F, G, H, I, J, or other more comprehensive plan	➠	Regence Base Plan (A)* Regence Cascade Plan (C) Regence Alpine Plan (E) Regence Vista Plan (F)
Medicare+Choice plan	➠	You may not be eligible for all plans. Please contact us for details.

**The Base Plan is the only plan available for disabled persons under age 65.*

PLEASE COMPLETE THE HEALTH STATEMENT IF NONE OF THE ABOVE SITUATIONS APPLIES TO YOU.

Authorization signature required on Page 4.

HEALTH STATEMENT

Washington State law requires that the health statement be completed by the applicant or the applicant's relative, legal guardian, or physician.

Please indicate whether or not you have received treatment for any of the following conditions within the last five years. Each condition must be checked yes or no.

Yes	No	Condition
❒	❒	1. AIDS or HIV positive
❒	❒	2. Arthritis
❒	❒	3. Alcoholism
❒	❒	4. Alzheimer's Disease
❒	❒	5. Back trouble
❒	❒	6. Cancer
❒	❒	7. Cataracts
❒	❒	8. Diabetes
❒	❒	9. Emphysema/lung problems
❒	❒	10. Gall bladder problems
❒	❒	11. Glaucoma
❒	❒	12. Hardening of the arteries
❒	❒	13. Heart trouble
❒	❒	14. High blood pressure
❒	❒	15. Intestinal problems
❒	❒	16. Kidney/bladder problems
❒	❒	17. Liver problems
❒	❒	18. Parkinson's Disease
❒	❒	19. Prostate problems
❒	❒	20. Psychiatric care
❒	❒	21. Stroke
❒	❒	22. Have you been hospitalized or had surgery in the past five years?

Please provide details of any "yes" answers to questions 1 through 22.
(If more space is needed, please attach another sheet of paper.)

ITEM NO.	YEAR	NAME OF DISEASE OR INJURY	SURGERY YES / NO	NAME & ADDRESS OF HOSPITAL OR PHYSICIAN

Please list any prescription drugs you are taking.
(If more space is needed, please attach another sheet of paper.)

PRESCRIPTION DRUGS	REASON TAKEN

Authorization signature required on Page 4.

AUTHORIZATION SIGNATURE

I authorize any physician, hospital or other provider of service to disclose to Regence BlueShield any medical information that may be requested. I understand that such information will be kept confidential, except as may be necessary to administer the provisions of my contract. I understand that any charge for obtaining the information will be my responsibility. I also understand that any false or misrepresented information or statements in this application shall bar the right to benefits and may result in retroactive termination of coverage and repayment of claims.

I understand that a true copy of this application will be attached to my contract when it is issued.

I hereby authorize the Health Care Financing Administration (Medicare) to release to Regence BlueShield any information from Title XVIII (Medicare) that is required to process my claims in conjunction with Medicare, if applicable. This authorization is ongoing for as long as I am or will be eligible for Medicare and remain enrolled in this plan.

By my signature below, I acknowledge that I have received a copy of the following (check all that apply):

❒ The Buyer's Guide for People with Medicare

❒ Notice of Replacement Coverage

❒ Outline of Coverage

Signature _____ Date _____

AGENT/BROKER INFORMATION

If application is being made through a broker or agent, he or she must complete the following and the notice of replacement included with this application, if appropriate. If all information is not completed, the application will be returned.

1. List any other medical or health insurance policies sold to the applicant: _____

_____

2. List policies that are still in force: _____

_____

3. List policies sold in the past five years that are no longer in force: _____

_____

Agent/Broker Name	Agent/Broker Number

I certify, to the best of my knowledge, that the applicant has truthfully completed the application and all health problems are listed. I further certify that I have verified that the person applying for coverage is eligible for Parts A and B of Medicare.

_____ _____

Agent/Broker Signature Date